		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036848

Facility Name: SKYVIEW TERRACE

Address: 1021 NORTH CHURCH STREET (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 245-4174 **Fax #** (217) 243-5901

IDPA ID Number: 36-1274300

Date of Initial License for Current Owners: 01/31/91

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MELVIN SIEGEL

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	113	Skilled (SNF)	113	41,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,339	2,339	8
9	SNF/PED					9
10	ICF	23,552	2,816		26,368	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,552	2,816	2,339	28,707	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.60%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/31/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 2,339

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	106,020	8,692	9,463	124,175		124,175		124,175			1
2	Food Purchase		113,985		113,985	(7,183)	106,802	(770)	106,032			2
3	Housekeeping	63,736	16,661		80,397		80,397		80,397			3
4	Laundry	31,867	8,825		40,692		40,692		40,692			4
5	Heat and Other Utilities			68,030	68,030		68,030	1,125	69,155			5
6	Maintenance	27,477	15,171	17,526	60,174		60,174	(3,880)	56,294			6
7	Other (specify):*			6,428	6,428		6,428	180	6,608			7
8	TOTAL General Services	229,100	163,334	101,447	493,881	(7,183)	486,698	(3,345)	483,353			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,018,654	49,198	9,519	1,077,371		1,077,371	11,418	1,088,789			10
10a	Therapy			954	954		954		954			10a
11	Activities	33,263	1,506	3,300	38,069		38,069	(3,300)	34,769			11
12	Social Services	35,665			35,665		35,665		35,665			12
13	Nurse Aide Training			352	352		352		352			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,087,582	50,704	20,125	1,158,411		1,158,411	8,118	1,166,529			16
	C. General Administration											
17	Administrative	64,643		32,400	97,043		97,043	13,413	110,456			17
18	Directors Fees											18
19	Professional Services			220,260	220,260		220,260	(163,010)	57,250			19
20	Dues, Fees, Subscriptions & Promotions			23,582	23,582		23,582	(15,508)	8,074			20
21	Clerical & General Office Expenses	58,379	14,137	36,774	109,290		109,290	19,219	128,509			21
22	Employee Benefits & Payroll Taxes			189,240	189,240	7,183	196,423		196,423			22
23	Inservice Training & Education			3,074	3,074		3,074	424	3,498			23
24	Travel and Seminar			1,982	1,982		1,982	7,191	9,173			24
25	Other Admin. Staff Transportation			5,542	5,542		5,542	6,501	12,043			25
26	Insurance-Prop.Liab.Malpractice			132,000	132,000		132,000		132,000			26
27	Other (specify):*			27,016	27,016		27,016	(13,061)	13,955			27
28	TOTAL General Administration	123,022	14,137	671,870	809,029	7,183	816,212	(144,831)	671,381			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,439,704	228,175	793,442	2,461,321		2,461,321	(140,058)	2,321,263			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SKYVIEW TERRACE #0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,358	17,358		17,358	30,190	47,548			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,992	16,992		16,992	98,217	115,209			32
33	Real Estate Taxes			56,671	56,671		56,671		56,671			33
34	Rent-Facility & Grounds			127,202	127,202		127,202	(120,095)	7,107			34
35	Rent-Equipment & Vehicles			21,716	21,716		21,716	5,310	27,026			35
36	Other (specify):*											36
37	**TOTAL Ownership**			239,939	239,939		239,939	13,622	253,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,460	41,166	70,626		70,626		70,626			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,867	61,867		61,867		61,867			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		29,460	103,033	132,493		132,493		132,493			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,439,704	257,635	1,136,414	2,833,753		2,833,753	(126,436)	2,707,317			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,833	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(770)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(16,823)	21		18
19	Entertainment		20		19
20	Contributions	(2,291)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,016)	27		24
25	Fund Raising, Advertising and Promotional	(13,572)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(5,984)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,623)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(64,813)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (64,813)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (126,436)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SKYVIEW TERRACE

ID# 0036848

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY]	$ (5,984)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,984)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKYVIEW TERRACE # 0036848 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(770)	0	0	0	0	0	0	0	0	0	0	(770)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,125	0	0	0	0	0	0	0	0	0	1,125	5
6	Maintenance	0	(3,880)	0	0	0	0	0	0	0	0	0	(3,880)	6
7	Other (specify):*	0	180	0	0	0	0	0	0	0	0	0	180	7
8	**TOTAL General Services**	(770)	(2,575)	0	0	0	0	0	0	0	0	0	(3,345)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	11,418	0	0	0	0	0	0	0	0	0	11,418	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,300)	0	0	0	0	0	0	0	0	0	(3,300)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	8,118	0	0	0	0	0	0	0	0	0	8,118	16
	C. General Administration													
17	Administrative	0	13,413	0	0	0	0	0	0	0	0	0	13,413	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(163,010)	0	0	0	0	0	0	0	0	0	(163,010)	19
20	Fees, Subscriptions & Promotions	(15,863)	355	0	0	0	0	0	0	0	0	0	(15,508)	20
21	Clerical & General Office Expenses	(22,807)	0	42,026	0	0	0	0	0	0	0	0	19,219	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	424	0	0	0	0	0	0	0	0	424	23
24	Travel and Seminar	0	0	7,191	0	0	0	0	0	0	0	0	7,191	24
25	Other Admin. Staff Transportation	0	0	6,501	0	0	0	0	0	0	0	0	6,501	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(27,016)	0	13,955	0	0	0	0	0	0	0	0	(13,061)	27
28	**TOTAL General Administration**	(65,686)	(149,242)	70,097	0	0	0	0	0	0	0	0	(144,831)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(66,456)	(143,699)	70,097	0	0	0	0	0	0	0	0	(140,058)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKYVIEW TERRACE # 0036848 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,833	0	425	24,932	0	0	0	0	0	0	0	30,190	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	105	98,112	0	0	0	0	0	0	0	98,217	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,107	(127,202)	0	0	0	0	0	0	0	(120,095)	34
35	Rent-Equipment & Vehicles	0	0	5,310	0	0	0	0	0	0	0	0	5,310	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,833	0	12,947	(4,158)	0	0	0	0	0	0	0	13,622	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,623)	(143,699)	83,044	(4,158)	0	0	0	0	0	0	0	(126,436)	45

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES		BOOKKEEPING
		PARK RIDGE TERRACE	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE	SKYVIEW NURSING	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD	ASSOCIATES LTD		
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTAN	$ 13,200			$	$ (13,200)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	3,180				(3,180)	2
3	V	11	ACTIVITIES CONSULTANT	3,300				(3,300)	3
4	V	19	ADMIN. /BKKP. FEES	110,580				(110,580)	4
5	V	19	ADMIN. /CONSULT. FEES	54,960				(54,960)	5
6	V								6
7	V	5	ELECTRICITY/GAS				1,125	1,125	7
8	V	6	MAINTENANCE				9,320	9,320	8
9	V	7	SCAVENGER				180	180	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				14,598	14,598	10
11	V	17	ADMINISTRATIVE SALARIES				13,413	13,413	11
12	V	19	PROFESSIONAL FEES				2,530	2,530	12
13	V	20	ADVERTISING				355	355	13
14	Total			$ 185,220			$ 41,521	$ * (143,699)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	$	MELVIN ENTERPRISES, LTD.		$ 42,026	$ 42,026	15
16	V	23	SEMINARS				424	424	16
17	V	24	TRAVEL				7,191	7,191	17
18	V	25	TRANSPORTATION				6,501	6,501	18
19	V	27	EMPLOYEE BENEFITS				13,955	13,955	19
20	V	30	DEPRECIATION (SL)				425	425	20
21	V	32	INTEREST				105	105	21
22	V	34	OFFICE RENT				7,107	7,107	22
23	V	35	EQUIPMENT RENT				5,310	5,310	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 83,044	$ * 83,044	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 127,202	SKYVIEW NURSING ASSOCIATES		$	$ (127,202)	15
16	V	30	DEPRECIATION				24,932	24,932	16
17	V	32	INTEREST				98,112	98,112	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 127,202			$ 123,044	$ * (4,158)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4		SEE ATTACHED SCHEDULE									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAVIN ENTERPRISES, LTD.
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	154,308	7	$ 6,048	$	28,707	$ 1,125	1
2	6	MAINTENANCE	PATIENT DAYS	154,308	7	50,100		28,707	9,320	2
3	7	SCAVENGER	PATIENT DAYS	154,308	7	966		28,707	180	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	154,308	7	78,470		28,707	14,598	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	154,308	7	72,100	72,100	28,707	13,413	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	154,308	7	13,601		28,707	2,530	6
7	20	ADVERTISING	PATIENT DAYS	154,308	7	1,910		28,707	355	7
8	21	TOTAL OFFICE	PATIENT DAYS	154,308	7	225,899	174,769	28,707	42,026	8
9	23	SEMINARS	PATIENT DAYS	154,308	7	2,280		28,707	424	9
10	24	TRAVEL	PATIENT DAYS	154,308	7	38,655		28,707	7,191	10
11	25	TRANSPORTATION	PATIENT DAYS	154,308	7	34,943		28,707	6,501	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	154,308	7	75,013		28,707	13,955	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	154,308	7	2,285		28,707	425	13
14	32	INTEREST	PATIENT DAYS	154,308	7	566		28,707	105	14
15	34	OFFICE RENT	PATIENT DAYS	154,308	7	38,200		28,707	7,107	15
16	35	EQUIPMENT RENT	PATIENT DAYS	154,308	7	28,543		28,707	5,310	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 669,579	$ 246,869		$ 124,565	25

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SKYVIEW NURSING ASSOCIATES
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY						$	$			$	1
2	SKYVIEW NURSING ASSOCIATES											2
3	SUCCESS NATIONAL BANK		X	MORTGAGE	$11,746.00	2/97	1,090,000	1,052,598		9.5000	98,112	3
4												4
5	MGMT CO ALLOCATION										105	5
	Working Capital											
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	06/29/99	150,000	282,872		5.2500	14,297	6
7	CANANWILL		X	INSURANCE FINANCIAL							2,695	7
8												8
9	TOTAL Facility Related				$11,746.00		$ 1,240,000	$ 1,335,470			$ 115,209	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,240,000	$ 1,335,470			$ 115,209	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 26,667	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 27,414	2
3. Under or (over) accrual (line 2 minus line 1).		$ 747	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,924	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 56,671	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	30,976	8
	1998	30,393	9
	1999	26,453	10
	2000	26,667	11
	2001	27,414	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKYVIEW TERRACE COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0036848

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-17-204-013	NURSING HOME	$ 27,414.00	$ 27,414.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,414.00	$ 27,414.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,500 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1991	$ 43,632	1
2					2
3	TOTALS			$ 43,632	3

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		1991		$ 785,372	$ 24,932	31.5	$ 24,932	$	$ 272,384	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1993	1,792	46	20	90	44	825	9
10	VARIOUS			1994	1,801	46	20	90	44	810	10
11	GENERATOR REPAIRS			1996	2,508	95	20	125	30	823	11
12	VENT REPAIRS			1996	1,200	30	20	60	30	365	12
13	ROOF REPAIRS			1997	50,700	1,300	20	2,535	1,235	14,154	13
14	PAINT & WALLPAPER			1997	21,655	555	20	1,082	527	5,861	14
15	REPLACEMENT SWITCH IN GENERATOR			1998	1,037	27	20	51	24	230	15
16	WALLPAPER, HARDWARE FOR WALLS			1998	5,613	144	20	280	136	1,260	16
17	HANDRAILS			1998	2,579	66	20	128	62	577	17
18	FLOOR & COVE BASE			1998	12,944	332	20	647	315	2,912	18
19	PAINTING /CARPETING			1998	9,995	256	20	499	243	2,246	19
20	ROOM SIGNS			1998	1,095	28	20	54	26	243	20
21	WALLPAPER			1999	5,374	138	20	268	130	1,072	21
22	HAND RAIL BUMPER, CAP			1999	5,034	129	20	251	122	1,004	22
23	SOFFIT INSULATION			1999	4,638	119	20	231	112	924	23
24	VCT INSTALLATION, FLOOR PATCH, TILE			1999	13,515	347	20	675	328	2,700	24
25	ROOM SIGNS, FRAMED ARTWORK			1999	3,685	94	20	184	90	736	25
26	HEATERS AND AIR CONDITIONING UNITS			2000	4,032	147	27.5	147		367	26
27	BUILT IN CABINETS FOR ADM. AND BOOKKEEPING OFFICE			2000	6,500	236	27.5	236		590	27
28	VCT INSTALLATION,COVE BASES, TILES,VINYL SHEET			2000	13,488	490	27.5	490		1,225	28
29	GUARD RAILS			2001	788	29	27.5	29		43	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 955,345	$ 29,586		$ 33,084	$ 3,498	$ 311,351	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 151,993	$ 12,194	$ 12,811	$ 617	5-10 YR	$ 99,198	71
72	Current Year Purchases	2,549	510	127	(383)	10 YR	127	72
73	Fully Depreciated Assets							73
74	MGMT CO ALLOCATION		425	425				74
75	TOTALS	$ 154,542	$ 13,129	$ 13,363	$ 234		$ 99,325	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1988 CHEVROLET	1993	$ 9,422	$	$ 1,101	$ 1,101	10	$ 9,422	76
77	FACILITY	1991 PLYMOUTH VOYAGER	1994	8,520				5	8,520	77
78										78
79										79
80	TOTALS			$ 17,942	$	$ 1,101	$ 1,101		$ 17,942	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,171,461	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,715	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 47,548	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,833	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 428,618	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 7,601 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2000 CHEVROLET VAN	$ 825.00	$ 7,444	17
18	FACILITY	2002 FORD VAN	762.00	3,075	18
19		2000 CHEVY BLAZER	400.00	3,596	19
20					20
21	TOTAL		$ 1,987.00	$ 14,115	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE 40

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		352		352
9	TOTALS	$	$ 352	$	$ 352
10	SUM OF line 9, col. 1 and 2 (e)	$ 352			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 12,701	$		$ 12,701	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,441			6,441	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			22,024			22,024	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				21,742		21,742	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): ENTERAL FEEDING	39-2 39-2					563 7,155		563 7,155	13
14	TOTAL			$		$ 41,166	$ 29,460		$ 70,626	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SKYVIEW TERRACE # 0036848 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (145,636)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	612,670		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,397		6
7	Other Prepaid Expenses	612		7
8	Accounts Receivable (owners or related parties)	758,955		8
9	Other(specify): Real Estate Escrow Deposit	16,535		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,291,533	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	169,973		15
16	Equipment, at Historical Cost	140,515		16
17	Accumulated Depreciation (book methods)	(122,686)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	323		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 188,125	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,479,658	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 220,452	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,311		28
29	Short-Term Notes Payable	1,099,785		29
30	Accrued Salaries Payable	38,813		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,326		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,924		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,467,611	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,467,611	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,047	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,479,658	$	48

***(See instructions.)**

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 459,028	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	191	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 459,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(446,795)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) TREASURY STOCK	(377)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (447,172)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 12,047	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,375,974	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,375,974	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,966	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,966	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,386,958	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	493,881	31
32	Health Care	1,158,411	32
33	General Administration	809,029	33
	B. Capital Expense		
34	Ownership	239,939	34
	C. Ancillary Expense		
35	Special Cost Centers	70,626	35
36	Provider Participation Fee	61,867	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,833,753	40
41	**Income before Income Taxes (line 30 minus line 40)****	(446,795)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (446,795)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,204	$ 57,588	$ 26.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,972	4,201	75,077	17.87	3
4	Licensed Practical Nurses	21,406	22,371	357,487	15.98	4
5	Nurse Aides & Orderlies	50,187	53,061	481,792	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,819	4,081	33,263	8.15	10
11	Social Service Workers	3,681	3,894	35,665	9.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,968	14,563	106,020	7.28	15
16	Dishwashers					16
17	Maintenance Workers	1,909	2,258	27,477	12.17	17
18	Housekeepers	10,053	10,876	63,736	5.86	18
19	Laundry	4,272	4,659	31,867	6.84	19
20	Administrator	2,330	2,394	64,643	27.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,890	4,074	52,395	12.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	4,018	4,228	52,694	12.46	33
34	TOTAL (lines 1 - 33)	125,593	132,864	$ 1,439,704 *	$ 10.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,463	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	338	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	721	10-3	39
40	Physical Therapy Consultant	L	571	10a-3	40
41	Occupational Therapy Consultant	Y	383	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,300	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTANT	S	8,460	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 29,236		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KELLY MATHIS	ADMIN	0	$ 64,643
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,643

B. Administrative - Other

Description		Amount
FAMILY PARTNERS MANAGEMENT	MANAGEMENT FEE	$ 32,400
TOTAL (agree to Schedule V, line 17, col. 3)		$ 32,400
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		220,260
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 220,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,800
Unemployment Compensation Insurance	13,973
FICA Taxes	111,789
Employee Health Insurance	30,904
Employee Meals	7,183
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,774
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 196,423

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,212
Health Care Worker Background Check	1,642
(Indicate # of checks performed 117)	
MARKETING/ADV/PROMO	13,572
TRUST/FRANCHISE/CONTRIB/ETC	2,291
LICENSES & PERMITS	293
DUES & SUBSCRIPTIONS	4,372
MGMT CO ALLOCATION	355
TRUST/FRANCHISE/CONTRIB/ETC	(2,291)
Less: Public Relations Expense	(0)
Non-allowable advertising	(13,572)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,074

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,982
MGMT CO ALLOCATION	7,191
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,173

**See instructions.

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7								N/A					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $3893**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,867**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,183** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: SKYVIEW TERRACE **#0036848** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,463	
	REPAIRS & MAINTENANCE		0	
			0	9,463
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		10,128	
	ELECTRICITY		37,769	
	WATER		15,382	
	CABLE TV - LOBBY		4,751	
			0	68,030
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,130	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE CONSULTANT		13,200	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,882	
	FIRE SERVICE		314	
			0	
			0	
			0	17,526
7	**OTHER**			
	SCAVENGER		3,077	
	SECURITY SERVICE		3,351	6,428
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	8,460	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	338	
	PHARMACY CONSULTANT	XVIII B 39-2	721	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	9,519
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	571	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	383	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	954
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,300	
			0	3,300
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	352	352

Facility Name & ID Number SKYVIEW TERRACE **#0036848** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	32,400	32,400
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	10,167	
	ADMINISTRATIVE CONSULTANTS	XIX C	54,960	
	PROFESSIONAL FEES	XIX C	44,553	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		110,580	220,260
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,572	
	EMPLOYEE WANT ADS	XIX F	1,212	
	CONTRIBUTIONS	VI 20 XIX F	480	
	DUES & SUBSCRIPTIONS	XIX F	4,372	
	LICENSES & PERMITS	XIX F	493	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,811	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,642	23,582
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		931	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	16,823	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,011	
	MESSENGER SERVICE		1,009	
			0	36,774

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	111,789	
	UNEMPLOYMENT COMPENSATION	XIX D	13,973	
	WORKERS COMPENSATION INSURANC	XIX D	30,800	
	HOSPITALIZATION INSURANCE	XIX D	30,904	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,774	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	189,240
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,074	3,074
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,982	
			0	
			0	1,982
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,542	5,542
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		132,000	132,000
27	**OTHER**			
	BAD DEBTS	VI 24	27,016	
			0	27,016

GRAND TOTAL COLUMN 3 OTHER 793,442

SKYVIEW TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	113,985
LESS SALES TAX	(770)
NET FOOD	113,215
TOTAL PATIENT CENSUS	28,707
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	86121
ADD # EMPLOYEE MEALS/DAY	16
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	5840

PATIENT MEALS	86121
ADD EMPLOYEE MEALS	5840
TOTAL MEALS/YEAR	91961
NET FOOD	113215
DIVIDE TOTAL MEALS/YEAR	91961
COST PER MEAL	1.23
TIME EMPLOYEE MEALS	5840
EMPLOYEE MEAL RECLASSIFICATION	7183